EXHIBIT A

STATE OF MINNESOTA DISTRICT COURT

COUNTY OF HENNEPIN FOURTH JUDICIAL DISTRICT

Stephen Venable,

Plaintiff,

Court File Number: TBD

vs.

UnitedHealthcare Inc.,

Defendant.

The Honorable TBD

Case Code/Type: Contract

SUMMONS

THIS SUMMONS IS DIRECTED TO:

UnitedHealthcare, Inc.
via its Registered Agent:
CT Corporation System, Inc.
1010 Dale St N
St Paul, MN 55117-5603

1. **YOU ARE BEING SUED**. The Plaintiff has started a lawsuit against you. The Plaintiff's Complaint against you is attached to this Summons. Do not throw these papers away. They are official papers that affect your rights. You must respond to this lawsuit even though it may not yet be filed with the Court and there may be no court file number on this summons.

2. **YOU MUST REPLY WITHIN 21 DAYS TO PROTECT YOUR RIGHTS.** You must give or mail to the person who signed this summons **a written response** called an Answer within 21 days of the date on which you received this Summons. You must send a copy of your Answer to the person who signed this summons located at:

Elizabeth I. Wrobel
Wrobel & Smith, PLLP
1599 Selby Ave. #105
Saint Paul, MN, 55104

3. **YOU MUST RESPOND TO EACH CLAIM.** The Answer is your written response to the Plaintiff's Complaint. In your Answer you must state whether you agree or disagree with each paragraph of the Complaint. If you believe the Plaintiff should not be given everything asked for in the Complaint, you must say so in your Answer.

4. YOU WILL LOSE YOUR CASE IF YOU DO NOT SEND A WRITTEN RESPONSE TO THE COMPLAINT TO THE PERSON WHO SIGNED THIS SUMMONS. If you do not answer within 21 days, you will lose this case. You will not get to tell your side of the story, and the Court may decide against you and award the Plaintiff everything asked for in the Complaint. If you do not want to contest the claims stated in the complaint, you do not need to respond. A default judgment can then be entered against you for the relief requested in the complaint.

5. LEGAL ASSISTANCE. You may wish to get legal help from a lawyer. If you do not have a lawyer, the Court Administrator may have information about places where you can get legal assistance. **Even if you cannot get legal help, you must still provide a written Answer to protect your rights or you may lose the case.**

6. ALTERNATIVE DISPUTE RESOLUTION. The parties may agree to or be ordered to participate in an alternative dispute resolution process under Rule 114 of the Minnesota General Rules of Practice. You must still send your written response to the Complaint even if you expect to use alternative means of resolving this dispute.

Dated: 6/20/23

Elizabeth I. Wrobel, #271755
Wrobel & Smith, PLLP
1599 Selby Ave., Suite 105
St. Paul, MN 55104
Phone: 651-925-6658
Fax: 888-865-4347
Email: elizabeth@wrobelsmithlaw.com
ATTORNEYS FOR PLAINTIFFS

STATE OF MINNESOTA DISTRICT COURT

COUNTY OF HENNEPIN FOURTH JUDICIAL DISTRICT

Stephen Venable,

Plaintiff,

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UnitedHealthcare Inc.,

Defendant.

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COMPLAINT

NOW COMES the above-named Plaintiff, Stephen Venable, by attorneys Wrobel & Smith, PLLP, and for the Complaint against Defendant states and alleges as follows:

PARTIES

1. Stephen Venable resides in the City of Minneapolis, County of Hennepin and State of Minnesota. Mr. Venable has medical insurance coverage through a United HealthCare Insurance Company Conversion Policy – Conversion Plan 3 (hereinafter the "Plan").

2. Upon information and belief, UnitedHealthcare Inc. insures and administers the Plan.

3. Upon information and belief, Defendant UnitedHealthcare Inc. (hereinafter "UHC") is a foreign company incorporated in Delaware with corporate headquarters in Minnetonka, Minnesota.

FACTUAL ALLEGATIONS

Employment and Plan Coverage

4. Stephen Venable worked as chief in-house legal counsel for Jostens Learning Corporation ("Jostens"), where he had employer medical insurance benefits. In 1998, after leaving employment with Jostens and the going through the requisite "COBRA" (Consolidated Omnibus Budget Reconciliation Act) period, Mr. Venable converted his policy to an individual medical plan, known as a "conversion policy." The Plan is entitled "Conversion Plan 3" and became effective June 1998.

5. On May 19, 2009, Defendant sent Mr. Venable a copy of the most recent version of the Plan. In its cover letter, Defendant indicated that "United has initiated a national project to update our individual conversion policies and schedule of benefits in every state." See attached Exhibit A. The letter further stated that the Minnesota Department of Commerce approved the updated conversion policy.

6. Among other covered medical services, Mr. Venable's Conversion Plan 3 includes "Outpatient Prescription Drugs." (See page 13 of the Plan).

7. On December 20, 2012, Defendant sent Mr. Venable a Certificate of Coverage for individual conversion policy, Conversional Plan 3, along with a Schedule of Benefits. The Plan continued to cover "outpatient prescription drugs" (e.g. prescription medication). See attached Exhibit B.

8. On November 5, 2014, Defendant sent Mr. Venable correspondence encouraging him to purchase another individual medical policy through the Health Care Marketplace. However, the correspondence did specifically state that "... your current conversion coverage under Policy number 555999 will not be discontinued or terminated, unless you choose to end your current coverage."

9. Since the Plan's effective date, Mr. Venable has consistently paid his premiums for his conversation policy, with no gap in medical insurance coverage. Furthermore, Mr. Venable has not elected to purchase another individual medical plan through the Health Care Marketplace.

10. Pursuant to the terms of Mr. Venable's Plan, Defendant has been, among other things, approving and paying his medical claims, as well as reimbursing Mr. Venable 80% of the amount paid for his prescription medications. Defendant reimburses Mr. Venable for prescription medication after he submits a written claim with evidence of out-of-pocket expenses.

Defendant's Claims Handling

11. Defendant has reimbursed Mr. Venable for his outpatient prescription drugs for the last twenty-five years, since the Plan has been in effect.

Per his usual practice, starting on September 19, 2022, Mr. Venable submitted seven separate prescription medication claims for reimbursement to Defendant at their Atlanta, Georgia location. The claims were mailed to the same address to which Mr. Venable submitted claims in the past. Several of the recent claims were sent priority mail with tracking information to ensure proof of delivery.

12. To date, Defendant has not only failed to reimburse Mr. Venable for any of his prescription drug claims but also utterly failed to acknowledge receipt of his claims despite confirmation of delivery. Mr. Venable's out-of-pocket expenses for the prescription drug benefits total $3,361.10.

13. The Plan directs its members to contact "us" using the telephone number for Customer Care listed on their ID card, with any problems. Mr. Venable has made repeated telephone calls to UHC's Customer Care number on the back of his insurance card.

14. During the telephone calls the Customer Care representative verified the correct mailing address to which Mr. Venable mailed his claims, however, the representatives are unable to verify receipt of claims or provide any information about his policy. On several occasions, Mr. Venable has been transferred to various representatives, disconnected or on hold for excessive periods of time.

15. Moreover, when Mr. Venable recently attempted to schedule physical therapy, at the recommendation of a foot and ankle surgeon with Twin

Cities Orthopedic (TCO), TCO had difficulty verifying Mr. Venable's benefits with UHC. Mr. Venable participated in physical therapy in the past and indisputably has such benefits under the terms his Plan. Additionally, Defendant incorrectly informed TCO that Mr. Venable had COBRA medical coverage.

COUNT I - BREACH OF CONTRACT

16. Stephen Venable is currently insured through a United HealthCare Insurance Company Conversion Policy, Conversion Plan 3, from which medical and prescription claims are paid.

17. Mr. Venable's Plan has been in full force and effect since June 1998.

18. Plaintiff has submitted claims and demand for payment of outpatient prescription drug benefits from Defendant, in accordance with the policy coverage in effect.

19. Defendant has ignored and/or refused to pay benefits and otherwise meet its policy obligations to Mr. Venable.

20. Defendant has breached its policy and contractual obligations by failing and refusing to pay benefits to which Mr. Venable is entitled. There is no reasonable basis for Defendant's refusal to reimburse for medically necessary prescription medication.

21. As a result of Defendant's breach of contract, Mr. Venable has incurred approximately $3,361.10 in prescription expenses and is entitled to 80%

of his costs. Further, Mr. Venable will continue to incur prescription medication costs going forward.

22. Plaintiff is entitled to payment of the full benefits of the medical coverage for which he has contracted, as well as all costs incurred and future outpatient prescription drug benefits.

REQUEST FOR RELIEF

WHEREFORE, the Plaintiff prays for judgment in his favor and against the Defendant as follows:

1. For the full benefit of his prescription medication costs incurred, approximately $3,361.10;

2. For enforcement of future Plan compliance related to incurred outpatient prescription drug expenses or other medically necessary treatment;

3. All costs and expenses as allowed by Minnesota law;

4. For all taxable costs; and

5. For such other and further relief as the Court deems just and equitable.

Dated: 6/20/23

Elizabeth I. Wrobel, #271755
Wrobel & Smith, PLLP
1599 Selby Ave., Suite 105
St. Paul, MN 55104
Phone: 651-925-6658
Fax: 888-865-4347
Email: elizabeth@wrobelsmithlaw.com
ATTORNEYS FOR PLAINTIFFS

ACKNOWLEDGMENT

The undersigned hereby acknowledges that costs, disbursements, and reasonable attorney and witness fees may be awarded pursuant to Minn. Stat. 549.211, subdivision 2, to the party against whom the allegations in this pleading are asserted.

Dated: 6/20/23

Elizabeth I. Wrobel, #271755
Wrobel & Smith, PLLP
1599 Selby Ave., Suite 105
St. Paul, MN 55104
Phone: 651-925-6658
Fax: 888-865-4347
Email: elizabeth@wrobelsmithlaw.com
ATTORNEYS FOR PLAINTIFFS

UnitedHealthcare®
A UnitedHealth Group Company

Conversion Customer Service Unit
450 Columbus Boulevard 12NA
Hartford, CT 06103

May 19th, 2009

Stephen Venable
4910 Russell Ave South
Minneapolis, MN 55410

RE: United HealthCare Insurance Company
Minnesota Conversion Policies

Dear Stephen:

Enclosed please find your updated United HealthCare Insurance Company ("United") Conversion Policy and Schedule of Benefits.

United has initiated a national project to update our individual conversion policies and schedule of benefits in every state.

We've recently received approval from the Minnesota Department of Commerce for the updated Minnesota Individual Conversion Policy and schedule of benefits. Please note that United hasn't changed the conversion benefits, we've simply updated the language to reflect current Minnesota laws and regulations. Additionally, due to the national project, we've incorporated standard, concise and more "user friendly" language.

Please contact UnitedHealthcare Conversion Unit Customer Service at 1-866-747-1019 if you have any questions.

Thank you,

Individual Conversion Unit

ENC:

Qualified Plan #3

Indemnity Conversion Policy

United HealthCare Insurance Company

Policy

This Policy is a legal document between United HealthCare Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Subscriber's application and payment of the required Premium.

The Policy includes:

- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without your approval.

On its effective date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any Policy we issue to you in the future.

This Policy will take effect on the date that we specify in writing. Coverage under this Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of your location. This Policy will remain in effect as long as the Premium is paid when due, subject to termination of this Policy.

We are delivering the Policy in the State of Minnesota. The Policy is governed by the laws of the State of Minnesota.

Right of Cancellation within First Ten Days

You may cancel this Policy by delivering or mailing a written notice to:

United HealthCare Insurance Company

Attention: Individual Conversion Unit

450 Columbus Blvd.

CT030-12NA

Hartford, CT 06103

This Policy must be returned before midnight the tenth day after the date you receive this Policy. Notice given by mail and return of this Policy by mail are effective when postmarked, properly addressed, and postage prepaid. We will return all premiums, fees and charges if applicable, within ten days after receiving notice of cancellation and the returned Policy. The Policy will then be considered void from the beginning and you must then pay any claims incurred prior to cancellation.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of the Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to United HealthCare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share

You must pay a Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other

Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time in our discretion. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay for Covered Health Services

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines, in our sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. You may be billed for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

Conversion Policy Table of Contents

EXHIBIT A

Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible and Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services and/or any Maximum Policy Benefit).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for notifying us or obtaining prior authorization.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

2. Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Benefits also include Diabetes Services for Covered Person with gestational, type I or type II diabetes.

3. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you will be responsible for any cost difference between the piece you rent or purchase and the piece we have determined is the most cost-effective.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services - Diabetic Self-Management Items*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

4. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

5. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

6. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

7. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, Emergency room Physicians, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)
- Communicator or interpreter services performed by a private duty nurse or personal care assistant to a ventilator-dependent Covered Person during a transition period to assure adequate training of the Hospital staff to communicate with the patient and to understand the unique comfort, safety, and personal care needs of the patient.

8. Infertility Services

Services for the treatment of infertility, except for invitro fertilization services, when provided by or under the direction of a Physician, limited to the following procedures:

- Diagnosis and diagnostic tests.
- Medication
- Surgery

To be eligible for Benefits, the Covered Person must meet all of the following:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35.
- Be under age 44, if female.
- Have infertility that is not related to voluntary sterilization or failed reversal of voluntary sterilization.

9. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services.*

10. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury.*

11. Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when the Covered Person has a Body Mass Index (BMI) of greater than 40.

12. Oral Surgery

Oral surgery services received in a Physician's or dentist's office or an Alternate Facility. Benefits are limited to oral surgery for:

- Partially or completely unerupted impacted teeth.
- A tooth root without the extraction of the entire tooth (this does not include a root canal).
- The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

13. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

14. Outpatient Prescription Drugs

Drugs and medicine which can be legally obtained only with a Physician's prescription including:

- Antipsychotic drugs prescribed to treat emotional disturbances or mental Illness.
- Off-label drugs that are prescribed for treatments other than those stated in the labeling approved by the FDA.

15. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

16. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services for Preventive Care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office and professional sign language interpreter services.

17. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for the mother for prenatal care, postnatal care, delivery, and any related complications.

For purposes of this benefit ""prenatal care services"" means the comprehensive package of medical and psychosocial support provided throughout the pregnancy, including risk assessment, serial surveillance, prenatal education, and use of specialized skills and technology, when needed, as defined by Standards for Obstetric-Gynecologic Services issued by the American College of Obstetricians and Gynecologists.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

If discharge occurs earlier than the specified time periods, benefits will be provided for post-delivery care for the mother and her newborn. Post-delivery care consists of a minimum of one home visit by a registered nurse. Services provided by the registered nurse include, but are not limited to, the following:

- Parent education
- Assistance and training in breast and bottle feeding.
- Conducting any necessary and appropriate clinical tests.

The home visit must be conducted within four days following discharge of the mother and her child.

18. Preventive Care Services

Services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Examples of preventive medical care are:

Physician office services:

- Routine physical examinations.
- Well baby and well child care.
- Immunizations
- Hearing screening.
- Child health supervision services. For purposes of this benefit, ""child health supervision services"" means pediatric preventive services, appropriate immunizations, development assessments, and laboratory services appropriate to the age of a child from birth to age 6 and appropriate immunizations from age 6 to 18, as defined by Standards of Child Health Care issued by the American Academy of Pediatrics. Benefits include at least:
  - 5 visits from birth to 12 months.
  - 3 visits from 12 months to 24 months.
  - 1 visit per year from 24 months to 72 months.

Lab, X-ray or other preventive tests:

- Screening mammography.
- Screening colonoscopy or sigmoidoscopy.
- Cervical cancer screening including pap smears.
- Prostate cancer screening including a prostate-specific antigen blood test and a digital rectal examination for:
  - Men age 40 or older who are symptomatic or in a high-risk category.
  - All men age 50 or older.
- Bone mineral density tests.
- Ovarian cancer surveillance tests for women who are at risk for ovarian cancer. For purposes of this benefit, the following definitions apply:
  - ""At risk for ovarian cancer"" means:
    - Having a family history with any of the following:
      - One or more first or second degree relatives with ovarian cancer.
      - Clusters of women relatives with breast cancer.
      - Nonpolyposis colorectal cancer.
    - Testing positive for BRCA1 or BRCA2 mutations.
  - ""Surveillance tests for ovarian cancer"" means annual screening using any of the following:
    - CA-125 serum tumor marker testing.
    - Pelvic examination.
    - Other proven ovarian cancer screening tests currently being evaluated by the federal Food and Drug Administration or by the National Cancer Institute.

19. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Speech aid prosthetics and tracheo-esophageal voice prosthetics.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.

- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

20. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly or functional defect. The primary result of the procedure is not a changed or improved physical appearance. The attending Physician shall determine if a Congenital Anomaly has resulted in a functional defect.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy related services.

21. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment

Short-term outpatient rehabilitation services, limited to:

- Physical therapy.
- Occupational therapy.
- Chiropractic Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.

22. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient.* Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for anesthesiologists, consulting Physicians, pathologists and radiologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

24. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

25. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services.*

26. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea. As technology changes, the above referenced benefits will be subject to modifications in the form of additions or deletions, when appropriate.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

27. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury.*

Additional Benefits Required By Minnesota Law

28. Cleft Lip and Cleft Palate Services

Inpatient and outpatient services received to treat or manage birth defects known as cleft lip and cleft palate. Benefits include both medical and dental treatment of cleft lip and cleft palate up to the limiting age for Dependent child coverage. Examples of benefits include, but are not limited to orthodontic and oral surgery. Benefits for individuals age 19 up to the limiting age for Dependent child coverage are limited to expenses from treatment that was scheduled or initiated prior to the Dependent turning age 19.

If orthodontic services are eligible for coverage under a dental insurance plan, the dental plan shall be primary and this Policy shall be secondary. Payment for dental or orthodontic treatment not related to cleft lip or cleft palate is not covered under this Benefit.

29. Dental Anesthesia

Anesthesia and associated Hospital or Alternate Facility charges when the dentist and Physician determine that the services are necessary for the safe and effective treatment of a dental condition for a Covered Person who:

- Is a child under age 5.
- Is disabled.
- Has a medical condition and requires hospitalization or general anesthesia for dental treatment.

Benefits are also provided for general anesthesia and treatment provided by a dentist for a medical condition that is normally covered by this Policy, regardless of whether the services are provided in a Hospital, Alternate Facility, or dental office. This Policy does not provide Benefits for dental services. Excluded dental services are described under *Dental* in *Section 2: Exclusions and Limitations.*

30. Diabetes Services - Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including, but not limited to:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment.*
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.

31. Hearing Aids for Children

Hearing aids for children age 18 or younger which are required for the correction of a hearing loss (a reduction in the ability to perceive sound which may range from slight to complete deafness) that is not correctable by other covered procedures. Hearing aids are electronic amplifying devices designed to bring sound more effectively to the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing

32. Lyme Disease Treatment

Treatment of Lyme Disease.

33. Mental Health Services - Inpatient and Intermediate

Mental Health Services received on an inpatient or Intermediate Care basis in a Hospital or an Alternate Facility.

The Mental Health/Substance Abuse Designee, may help you determine the appropriate setting for treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

Benefits also include Mental Health Services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist. We must receive a copy of the court order and the behavioral care evaluation. Benefits include the:

- Evaluation is performed by a provider.

- Care included in the court-ordered individual treatment plan if the care is covered by this Policy and ordered to be provided by a Provider as required by rule or law.

Mental Health Services may be provided by or under the direction of the Mental Health/Substance Abuse Designee. You may contact the Mental Health/Substance Abuse Designee for assistance regarding Benefits for Inpatient/Intermediate Mental Health Services.

34. Mental Health Services - Outpatient

Mental Health Services received on an outpatient basis in a provider's office, Hospital, licensed Community Mental Health Center, or licensed Mental Health Clinic, including:

- Mental health evaluations and assessment, including court-ordered behavioral care evaluations. Benefits include treatment required as a result of such behavioral care evaluations.
- Diagnosis.
- Treatment planning.
- Referral services.
- Medication management.
- Short-term individual, family and group therapeutic services (including intensive outpatient therapy).
- Crisis intervention.

You may contact the Mental Health/Substance Abuse Designee for assistance regarding your Benefits for outpatient Mental Health Services.

Benefits also include Mental Health Services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist. We must receive a copy of the court order and the behavioral care evaluation. Benefits include the:

- Evaluation if performed by a provider.
- Care included in the court-ordered individual treatment plan if the care is covered by this Policy and ordered to be provided by a provider as required by rule or law.

35. Phenylketonuria Treatment

Special dietary treatment for Phenylketonuria when recommended by a Physician. Special dietary treatment includes enteral formulas and low protein modified food products.

Special dietary treatment does not include non-enteral formulas or food products that are naturally low in protein.

36. Port-Wine Stain Treatment

Elimination of or maximum feasible treatment of port-wine stains.

37. Scalp Hair Prosthesis

Scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata.

38. Substance Abuse Services - Inpatient and Outpatient

Substance Abuse Services received in on an Inpatient basis in a Hospital or Alternate Facility, or on an Outpatient basis in a provider's office or Alternate Facility.

The Mental Health/Substance Abuse Designee may help you determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. You may contact the Mental Health/Substance Abuse Designee for assistance with your Benefits.

Benefits are provided for Substance Abuse treatment while a Covered Person is committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense if both of the following are true:

- A court of competent jurisdiction makes a preliminary determination based on a chemical use assessment that treatment may be appropriate and includes this determination as part of the sentencing order.
- The department of corrections makes a determination that treatment is appropriate based on a chemical assessment conducted while the individual is in the custody of the department.

39. Temporomandibular and Craniomandibular Joint Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and craniomandibular joint disorder (CMJ) and associated muscles if the treatment is administered or prescribed by a Physician or dentist.

Diagnosis: Examination, radiographs and applicable imaging studies, and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis, and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations, and TMJ or CMJ implants.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, except that Benefits for hospitalizations and anesthesia are provided as described under *Dental Anesthesia* in *Section 1: Covered Health Services.)*

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of cancer, cleft lip or cleft palate except when Benefits for cleft lip and cleft palate treatment are provided as described under *Cleft Lip and Cleft Palate Services* in *Section 1: Covered Health Services*.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth.
   - Medical or surgical treatments of dental conditions.
   - Services to improve dental clinical outcomes.

   This exclusion does not apply to dental services for which Benefits are provided as described under *Oral Surgery* in *Section 1: Covered Health Services*.
3. Dental implants, bone grafts, and other implant-related procedures.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned, or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to newborn children.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces.
3. The following items are excluded, even if prescribed by a Physician:
   - Blood pressure cuff/monitor.
   - Enuresis alarm.
   - Home coagulation testing equipment.
   - Non-wearable external defibrillator.
   - Trusses.
   - Ultrasonic nebulizers.
   - Ventricular assist devices.
4. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics.
5. Oral appliances for snoring.
6. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
7. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition. Refer to the definitions of Experimental or Investigational Service(s) and Unproven Services under Section 8: Defined Terms.

E. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services - Diabetes Self-Management and Training/Diabetic Eye Examination/Foot Care* in *Section 1: Covered Health Services.*
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics.
8. Shoe inserts.
9. Arch supports.

F. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings.
   - Ace bandages.
   - Gauze and dressings.
   - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services - Diabetic Self-Management Items* in *Section 1: Covered Health Services.*
- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services.*

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services.*

G. Mental Health

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.
4. Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements. However, Benefits are provided for court-ordered Mental Health Services as described under *Mental Health Services - Inpatient and Intermediate* and *Mental Health Services - Outpatient* in *Section 1: Covered Health Services.*
6. Residential treatment services for treatment of Mental Illness.
7. Services or supplies for the diagnosis or treatment of Mental Illness including any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with our level of care guidelines or best practices as modified from time to time.

   The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

H. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
   - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
   - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2 Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Phenylketonuria for which Benefits are provided as described under Phenylketonuria Treatment in *Section 1: Covered Health Services*.

3. Infant formula and donor breast milk. This exclusion does not apply to Phenylketonuria for which Benefits are provided as described under Phenylketonuria Treatment in *Section 1: Covered Health Services*.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes, and foods of any kind (including high protein foods and low carbohydrate foods).

I. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners, air purifiers and filters, dehumidifiers.
   - Batteries and battery chargers.
   - Breast pumps.
   - Car seats.
   - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners.
   - Electric scooters.
   - Exercise equipment.
   - Home modifications such as elevators, handrails and ramps.
   - Hot tubs.
   - Humidifiers.
   - Jacuzzis.
   - Mattresses.
   - Medical alert systems.
   - Motorized beds.
   - Music devices.
   - Personal computers.
   - Pillows.
   - Power-operated vehicles.
   - Radios.
   - Saunas.
   - Stair lifts and stair glides.
   - Strollers.
   - Safety equipment.
   - Speech generating devices.
   - Treadmills.
   - Vehicle modifications such as van lifts.
   - Video players.
   - Whirlpools.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:

- Pharmacological regimens, nutritional procedures or treatments.
- Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
- Skin abrasion procedures performed as a treatment for acne.
- Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
- Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
- Treatment for spider veins.
- Hair removal or replacement by any means.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services.*
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Breast reduction except as coverage is required by the *Women's Health and Cancer Right's Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services.*
5. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
6. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

K. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders.
5. Psychosurgery.
6. Sex transformation operations.
7. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
8. Biofeedback.
9. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; dental restorations.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea, temporomandibular and craniomandibular joint disorder. Benefits for temporomandibular and craniomandibular joint services are described under *Temporomandibular and Craniomandibular Joint Services* in *Section 1: Covered Health Services.*
11. Non-surgical treatment of obesity.

12. Stand-alone multi-disciplinary smoking cessation programs.

L. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - Has not been actively involved in your medical care prior to ordering the service, or
   - Is not actively involved in your medical care after the service is received.

   This exclusion does not apply to mammography.
4. Foreign language and sign language interpreters.

M. Reproduction

1. The following infertility treatment-related services:
   - Cryo-preservation and other forms of preservation of reproductive materials.
   - Long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
   - Donor services.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Maternity related medical services for Enrolled Dependent children.

N. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

O. Substance Abuse

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention.
3. Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
4. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Designee. However, Benefits are provided for Substance Abuse treatment while a Covered Person is committed to the custody of the commissioner of corrections as described under *Substance Abuse Services - Hospital, Residential and Outpatient* in *Section 1: Covered Health Services*.
5. Services or supplies for the diagnosis or treatment of alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following:
   - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions.
   - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.
   - Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.
   - Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.

   The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

P. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (*Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.*)
3. Health services for transplants involving permanent mechanical or animal organs.

Q. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at our discretion.

R. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis.
2. Custodial Care.
3. Domiciliary care.
4. Private duty nursing. This means nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:
   - No skilled services are identified.

- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Purchase cost and fitting charge for eye glasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants).
4. Purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices, except for hearing aids for children as described under *Hearing Aids for Children* in *Section 1: Covered Health Services*.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

T. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
   - Required solely for purposes of career, school, sports or camp, travel, employment, insurance, marriage or adoption.
   - Related to judicial or administrative proceedings or orders.
   - Conducted for purposes of medical research.
   - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
5. Health services for which you have no responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
6. Charges in excess of Eligible Expenses or in excess of any specified limitation.
7. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
8. Autopsy, except when requested by us and paid at our expense.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete an enrollment form. We will give the necessary forms to you. The Eligible Person must then submit the completed forms to us, along with the required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Who is Eligible for Coverage

We determine who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to a person who was a subscriber or enrolled dependent under a group policy issued by United HealthCare Insurance Company and who no longer is eligible for coverage under that group policy. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person and Subscriber, see *Section 8: Defined Terms*.

Eligible Persons must reside within the United States.

Dependent

Dependent generally refers to the Subscriber's spouse and children who were enrolled dependents under a group policy issued by United HealthCare Insurance Company and who no longer is eligible for coverage under that group policy. A Dependent also includes a newborn child, a child placed for adoption and an adopted child when that event occurs after the effective date of this Policy. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

New Eligible Persons and Dependents

Coverage for Eligible Persons and any Dependents who are no longer eligible under the group policy issued by United HealthCare Insurance Company from which they converted is effective on the date they become ineligible for group coverage. Coverage for Eligible Persons and Dependents whose continuation rights are expiring under a group policy issued by United HealthCare Insurance Company from which they converted begins on the day following expiration of the continuation period.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Court or administrative order

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible, except for newborn and adopted children.

Newborn children will be covered from the moment of birth even if the Subscriber has not enrolled the child for coverage. Coverage for adopted children will begin on the date that the child is placed for adoption even if the Subscriber has not enrolled the child for coverage. However, if any Premium is required in order for a newborn or adopted child to be covered, we shall be entitled to all Premiums that would have been collected had we been made aware of the new Dependent. We may withhold Benefits until the past due premium has been paid or reduce Benefits by the amount of past due Premiums that apply to each new Dependent.

Premiums

All Premiums are payable on a monthly basis, by the Subscriber to us at our offices. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

Premiums shall not be pro-rated based upon the Covered Person's effective date of coverage. A full months' Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Grace Period

A grace period of 30 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 30 day grace period, coverage may be canceled after the 30th day and the Subscriber shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums at any time. We shall give written notice of any change in Premium to the Subscriber at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in this Policy, as permitted by law. Your policy will not be cancelled or non-renewed except as set forth below.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **You Are No Longer Eligible**

  Your coverage ends on the last day of the calendar month in which you are no longer eligible to be an Enrolled Dependent. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

  Your coverage ends on the last day of the calendar month in which we receive written notice from you instructing us to end your coverage, or the date requested in the notice, if later. The Subscriber is responsible for providing written notice to us to end your coverage.

- **Attainment of the Maximum Policy Benefit**

  Your coverage ends on the date of attainment of the Maximum Policy Benefit as described in the *Schedule of Benefits*.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Subscriber that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

  You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation**

  Fraud or intentional misrepresentation (the Subscriber knowingly gave us false material information). Examples include false information relating to another person's eligibility or status as a Dependent.

  During the first two years the Policy is in effect, we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application to us for coverage under another Policy.

Section 5: How to File a Claim

Filing a Claim for Benefits

When you receive Covered Health Services, you are responsible for requesting payment from us. You must file the claim in a format that contains all the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in our discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the Current Procedural Terminology (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

You may not assign your Benefits under the Policy to a provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, in our discretion, pay a provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a provider with our consent, and the provider submits a claim for payment, you and the provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were medically appropriate.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint.You can request a complaint form. It will include:

- The telephone numbers for the Office of Health Care Consumer Assistance, Advocacy and Information and our Customer Services Department or persons equipped to advise you on complaint resolution.
- The address to which the form must be sent.
- A copy of our internal complaint procedure and applicable time limits as listed in this section.
- The toll-free telephone number of the Commissioner of Commerce and notification that you have the right to submit the complaint to the Commissioner of Commerce at any time.

Upon receipt of a written complaint, we will notify you within 10 days that the complaint was received, unless the complaint is resolved to your satisfaction within 10 days.

We will provide written notification of our decision regarding your written complaint within 30 days of receiving it. If we are unable to make a decision within 30 days due to circumstances outside our control, we will notify you that it may take up to 14 additional days to notify you of our decision. We will include the reason for the extension.

If the decision regarding a complaint is partially or wholly adverse to you, the notification of the adverse decision will inform you of your right to appeal the decision, our internal appeal process, and the process for initiating an appeal. The notification will also inform you of your right to submit the complaint to the Commissioner of Commerce for investigation and the toll-free telephone number for the commissioner.

Contact Information:

Minnesota Department of Commerce

85 - 7th Place East

Suite 500

St. Paul, MN 55101-2198

Phone: (800) 657-3602 (651) 296-2488

How to Appeal a Complaint Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or benefit confirmation prior to receiving medical care. If we adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols and standard cost-effectiveness analysis, you may appeal that decision pursuant to this process.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination or post-service claim determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

The appeal process permits the receipt of testimony, correspondence, explanations, or other information from you, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigation or presiding over the appeal.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures associated with urgent requests for Benefits, see Urgent Appeals That Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days

from receipt of the first level appeal decision. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

- If you appeal by hearing, the appeal will be conducted and you will be notified of the decision and all key findings within 45 days from our receipt of your written notice of appeal.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. We don't determine whether the pending health service is necessary or appropriate. That decision is between you and your Physician. If your appeal results in an adverse determination, the adverse determination will include notification of your right to external review.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Voluntary External Review Program

After you exhaust the appeal process, and you have received an adverse determination, you may submit a written request for an external review of the adverse determination to the commissioner of health. The written request must be accompanied by a filing fee of $25.00. The fee may be waived by the commissioner in cases of financial hardship.

The external review program is not available if our coverage determinations are based on Benefit exclusions or defined Benefit limits.

Contact us at the telephone number shown on your ID card for more information on the voluntary external review program.

Important Telephone Numbers

The toll-free telephone number of the Managed Care System Section is [800-657-3916]. You can also call [651- 201-5100].Contact us at the telephone number shown on your ID card for more information on the voluntary external review program

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your benefit plan and how it may affect you. We administer the benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We do not decide what care you need or will receive. You and your Physician make those decisions.
- We communicate to you decisions about whether the benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Statements by Subscribers

All statements made by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, made by the subscriber in the application for this policy, we will not use any statement made by a Subscriber:

- To void the Policy after it has been in force for a period of two years from the effective date of coverage.
- To deny any claim for Covered Health Services provided after that two-year period.

Incentives to Providers

We pay certain providers certain through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for certain providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - a group of providers receives a monthly payment from us for each Covered Person who selects a provider within the group to perform or coordinate certain health services. The providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific providers. From time to time, the payment method may change. If you have questions about whether your provider contracts with us and if that contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable Annual Deductible. We do not pass these rebates on to you, nor are they applied to any Annual Deductible or taken into account in determining your Coinsurance.

Interpretation of Benefits

We have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits*, and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, in our discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to

give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to this Policy

To the extent permitted by law we reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Subscriber.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Other Coverages

From time to time, we may request information in advance of any Premium due date of any Covered Person as to whether he or she is covered for similar benefits by another hospital, surgical or medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or by any other plan or program or similar benefits provided for, or available to, such person, pursuant to, or in accordance with the requirements of any statute. In the event similar benefits are available to or provided for the Covered Person in accordance with the requirements of any statute and if the statute does not make coverage under this Policy primary, then coverage under this Policy shall be secondary.

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this Policy, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

If the Injury or condition giving rise to subrogation or reimbursement involves a minor child, this section also applies to the parents or guardian of the minor child.

If the Injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Covered Person, this section will apply to any personal representative of the Covered Person.

We agree as follows:

- Subrogation applies only after you have received full recovery from another source.
- Our right of subrogation is subject to subtraction for actual monies paid to account for the pro rata share of your costs, disbursements, reasonable attorney fees and other expenses incurred in obtaining the recovery from another source (unless we are separately represented by an attorney).
- If we are separately represented by an attorney, we may enter into an agreement with you (through our attorneys) regarding the allocation of your costs, disbursements, reasonable attorney fees and other expenses. If we cannot reach agreement with you on the allocation of expenses, the matter will be subject to binding arbitration.
- Nothing in this section limits our right to recovery from another source which may otherwise exist at law.

- Full recovery does not include payments made by a health plan to or for the benefit of a Covered Person.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. If you want to bring a legal action against us you must do so within 3 years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such legal action against us.

You cannot bring any legal action against us for any other reason until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Subscriber, including the *Schedule of Benefits*, the Subscriber's application, and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Abuse Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits*, and any attached Riders and/or Amendments.

Chiropractic Treatment -the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Community Mental Health Center/Mental Health Clinic - a facility whose primary function is the diagnosis, treatment, and/or rehabilitation of persons with mental or nervous disorders which meets one of the following requirements:

- If the services of the facility are mandated by law, the facility is licensed or approved by the appropriate authority.
- If the services of the facility are not mandated by law, the facility meets all of the following requirements:
  - It is established and operated in accordance with any applicable laws.
  - It is an organization with its own governing body, administration and medical staff.
  - The medical responsibility for patients rests with a Physician.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us. However, in no event, will treatment of port-wine stains be considered a cosmetic procedure.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness substance abuse, or their symptoms.

- Consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below.
- Not provided for the convenience of the Covered Person, Physician, facility or any other person.
- Described in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" shall have the following meanings:

- "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community.
- "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

We maintain clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical protocols (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse, domestic partner or an unmarried dependent child of the Subscriber or the Subscriber's spouse who was previously covered under a group policy issued by United HealthCare Insurance Company from which you converted.

The term child also includes the following when the event occurs after the effective date of this Policy, subject to the requirements as described under *Adding New Dependents* in *Section 3: When Coverage Begins and Premiums*:

- A newborn child.
- A child place for adoption.
- A legally adopted child.
- A grandchild of the Subscriber or the Subscriber's covered spouse if the grandchild is financially dependent upon and resides with that covered grandparent continuously from birth.
- A child for whom the Subscriber or the Subscriber's covered spouse has been appointed legal guardian
- Any other person whom state or federal law requires to be treated as a dependent.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes an unmarried dependent child who is less than 25 years of age.
- A Dependent includes an unmarried dependent child of any age who is or becomes handicapped and dependent upon the Subscriber. For purposes of this definition, a handicapped dependent is a person who is and continues to be both:
  - Incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability.
  - Chiefly dependent upon the Subscriber for support and maintenance.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets one of the eligibility requirements specified below. An Eligible Person must reside within the United States. All references to a "subscriber", "dependent", and "enrolled dependent" below are references to a subscriber and/or dependent under the group policy issued by United HealthCare Insurance Company from which you converted.

- A subscriber who has been covered under a group policy immediately prior to termination of coverage under that policy.
- The dependent of a subscriber who has become ineligible to continue as an enrolled dependent because of the divorce of the former subscriber.
- The dependent of a deceased subscriber. The dependent must have been an enrolled dependent under the group policy immediately prior to the subscriber's death.
- The dependent of a subscriber who has become ineligible to continue as an enrolled dependent because of attaining the limiting age. The dependent must have been covered as an enrolled dependent under the group policy immediately prior to the dependent's date of ineligibility.

An Eligible Person does not include anyone who is:

- Eligible for or covered by federal Medicare coverage.
- Covered under another individual policy providing similar benefits or covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.
- Covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by another plan or program;
- Covered by or has similar benefits available by reason of state or federal law.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration* (FDA) to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.

- Drugs for the treatment of cancer if the drug is recognized for treatment of cancer in:
  - One of the following standard reference compendia:
    - The United States Pharmacopeia Drug Information;
    - The American Hospital Formulary Service Drug Information; or
  - One article found in a major peer reviewed medical journal that has recognized the drug or combination of drugs' safety and effectiveness for treatment of the indication for which it has been prescribed.

  However, benefits will not be provided when the FDA has determined a drug's use to be contraindicated, or when the drug is not approved for any indication by the FDA.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intermediate Care - Mental Health/Substance Abuse treatment that encompasses the following:

- Care at a partial hospital/day treatment program, which is a freestanding or Hospital-based program that provides services for at least 20 hours per week.
- Care through an intensive outpatient program, which is a freestanding or Hospital-based program that provides services for at least nine hours per week. This encompasses half-day (i.e. less than four hours per day) partial Hospital programs.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week; or
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Maximum Policy Benefit - The maximum amount that we will pay for Benefits during the entire period of time that you are enrolled under this Policy. Refer to the *Schedule of Benefits* for details about how the Maximum Policy Benefit applies.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Abuse Designee - the organization or individual, designated by us, that may provide or assist with arrangements for Mental Health Services and Substance Abuse Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Pharmaceutical Product(s) - FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Subscriber that includes all of the following:

- This *Policy*.
- The *Schedule of Benefits*.
- The Subscriber's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Subscriber.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Pre-implantation Genetic Diagnosis (PGD) - a screening test typically performed in conjunction with in vitro fertilization (IVF) in which one or two cells are removed from an embryo to be screened for genetic abnormalities.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of this Policy.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings is bracketed for possible name change.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Saving Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Subscriber - an Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) to whom this Policy is issued.

Substance Abuse Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance abuse disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care - Mental Health/Substance Abuse Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health*.
- We may, in our discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that we do not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies must be available in published peer-reviewed medical literature that would allow us to conclude that the service is promising but unproven.

The decision about whether such a service can be deemed a Covered Health Service is solely at our discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UnitedHealthcare®
A UnitedHealth Group Company

Conversion Customer Service Unit
PO Box 221709
Louisville, KY 40252

December 20, 2012

STEPHEN VENABLE
1916 SUMMIT AVENUE
ST PAUL, MN 55105

RE: United HealthCare Insurance Company
Minnesota Conversion Policies

Dear STEPHEN:

Enclosed please find a copy of your Certificate of Coverage for your Individual Conversion policy.

As per your Certificate, your deductible and maximum out of pocket are to be calculated on a calendar year basis. Our system has been updated to reflect this and beginning January 1, 2013, all claims will be processed on a calendar year basis. Your benefits will remain the same.

Please contact UnitedHealthcare Conversion Unit Customer Service at 1-800-641-4146, option 3 if you have any questions.

Thank you,

Individual Conversion Unit

ENC

EXHIBIT B

UnitedHealthcare Indemnity

United HealthCare Insurance Company

Schedule of Benefits-Plan 3

Accessing Benefits

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider.

You must show your identification card (ID card) every time you request health care services from a provider. If you do not show your ID card, providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you, this *Schedule of Benefits* will control.

Additional information about providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

As we determine, if one or more alternative health services that meets the definition of a Covered Health Service in the Policy under *Section 8: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness. After you contact us for pre-service Benefit confirmation, we will identify the Benefit level available to you.

The process and procedures used to define clinical protocols and cost-effectiveness of a health service and a listing of services subject to these provisions (as revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

For all other services we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time notice is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

Mental Health and Substance Abuse Services

You may contact the Mental Health/Substance Abuse Designee for assistance before you receive Mental Health Services and Substance Abuse Services. You can contact the Mental Health /Substance Abuse Designee at the telephone number on your ID card.

Benefits

Annual Deductibles, if applicable, are calculated on a calendar year basis.

Out-of-Pocket Maximums, if applicable, are calculated on a calendar year basis.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits. Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the Schedule of Benefits table.	$100 per Covered Person.
Out-of-Pocket Maximum	
The maximum you pay per year for the Annual Deductible and Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year.	$3,000 per Covered Person. The Out-of-Pocket Maximum includes the Annual Deductible.
Maximum Policy Benefit	

The maximum amount we will pay for Benefits during the entire period of time you are enrolled under the Policy.	$1,000,000 per Covered Person.

Coinsurance
Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services. Details about the way in which Eligible Expenses are determined appear at the end of the *Schedule of Benefits* table.

Benefit Limits

This Benefit plan does not have Benefit limits in addition to those stated below within the Covered Health Service categories in the *Schedule of Benefits* table.

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
1. Ambulance Services			
Emergency Ambulance	*Ground Ambulance:* 80%	Yes	Yes
	Air Ambulance: 80%	Yes	Yes
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	*Ground Ambulance:* 80%	Yes	Yes
	Air Ambulance: 80%	Yes	Yes
2. Diabetes Services - Diabetes Self-			

Covered Health Service	**Benefit** *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Management and Training/Diabetic Eye Examinations/Foot Care			
	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
3. Durable Medical Equipment			
	80%	Yes	Yes
4. Emergency Health Services - Outpatient			
	80%	Yes	Yes
5, Home Health Care			
	80%	Yes	Yes
6. Hospice Care			
	80%	Yes	Yes
7. Hospital - Inpatient Stay			
	80%	Yes	Yes
8. Infertility Services			
	80%	Yes	Yes
9. Lab, X-Ray and Diagnostics - Outpatient			
	80%	Yes	Yes
10. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
	80%	Yes	Yes
11. Obesity Surgery			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
12. Oral Surgery			
	80%	Yes	Yes

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
13. Ostomy Supplies			
	80%	Yes	Yes
14. Outpatient Prescription Drugs			
	80%	Yes	Yes
15. Physician Fees for Surgical and Medical Services			
	80%	Yes	Yes
16. Physician's Office Services - Sickness and Injury			
	80%	Yes	Yes
17. Pregnancy - Maternity Services			
	Prenatal Care Services 100% **All Other Maternity Services** Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits* except that an Annual Deductible, if applicable, will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
18. Preventive Care Services			
Physician office services: Child health supervision services from birth to age 6 and immunization for children age 6-18 are not subject to any deductible or coinsurance. **Lab, X-ray or other preventive tests:**	80% 80%	Yes Yes	Yes Yes
19. Prosthetic Devices			
	80%	Yes	Yes
20. Reconstructive Procedures			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
21. Rehabilitation Services - Outpatient Therapy and Chiropractic Treatment			
	80%	Yes	Yes
22. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	80%	Yes	Yes
23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Limited to 120 days per year.	80%	Yes	Yes
24. Surgery - Outpatient			
	80%	Yes	Yes
25. Therapeutic Treatments - Outpatient			
	80%	Yes	Yes
26. Transplantation Services			
	80%	Yes	Yes
27. Urgent Care Center Services			
	80%	Yes	Yes
Additional Benefits Required By Minnesota Law			
28. Cleft Lip and Cleft Palate Services			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits*.		
29. Dental Anesthesia			
	Depending upon where the Covered Service is provided, any applicable notification requirements will be the same as those		

Covered Health Service	**Benefit** ***(The Amount We Pay, based on Eligible Expenses)***	**Apply to the Out-of-Pocket Maximum?**	**Must You Meet Annual Deductible?**
	stated under each Covered Health Service category in this *Schedule of Benefits.*		
30. Diabetes Services - Diabetic Self-Management Items			
	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* or the Outpatient Prescription Drug Benefit.		
31. Hearing Aids For Children			
Limited to one hearing aid in each ear every 3 years.	80%	Yes	Yes
32. Lyme Disease			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
33. Mental Health Services - Inpatient and Intermediate			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
34. Mental Health Services - Outpatient			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
35. Phenylketonuria Treatment			
	80%	Yes	Yes
36. Port-Wine Stain Treatment			
	80%	Yes	Yes
37. Scalp Hair Treatment			
Limited to $350 per year.	80%	Yes	Yes
38. Substance Abuse Services - Hospital, Residential and Outpatient			
	Inpatient treatment: Benefits will be the same as those stated		

Covered Health Service	Benefit *(The Amount We Pay, based on Eligible Expenses)*	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	under *Hospital-Inpatient Stay* in this *Schedule of Benefits.* Outpatient treatment: Benefits will be the same as those stated under *Physician's Office Services* in this *Schedule of Benefits.*		
39. Temporomandibular Joint Services			
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this *Schedule of Benefits.*		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. You are responsible for paying, directly to the provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the Policy.

If one or more alternative health services that meets the definition of Covered Health Service in the Policy under *Section 8: Defined Terms* are clinically appropriate and equally effective for prevention, diagnosis or treatment of a Sickness, Injury, Mental Illness, substance abuse or their symptoms, we reserve the right to adjust Eligible Expenses for identified Covered Health Services based on defined clinical protocols. Defined clinical protocols shall be based upon nationally recognized scientific evidence and prevailing medical standards and analysis of cost-effectiveness.

Eligible Expenses are determined, based on the lesser of:

- For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
- When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the amount that the *Centers for Medicare and Medicaid Services (CMS)* would have paid under the Medicare program for the drug determined by either of the following:
  - Reference to available CMS schedules.
  - Methods similar to those used by CMS.
- Fee(s) that are negotiated with the provider.
- 50% of the billed charge.
- A fee schedule that we develop.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.